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DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS COMMITTEE

Working Party on Social Policy. Health Policy Statistics.

REFINEMENT AND EXTENSION OF THE INTERNATIONAL CLASSIFICATION FOR HEALTH ACCOUNTS (ICHA)

Meeting to be held at the Château de la Muette, Paris, 30 September and 1 October 2004, starting at 14:00 on the first day and ending at 17:00 on the second day

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NOTE BY THE SECRETARIAT

1. The OECD Secretariat published in May 2000 the first edition of the manual *A System of Health Accounts* (SHA). The SHA manual currently is used in a large and growing number of OECD and non-OECD countries as accounting framework for statistics on health expenditure and financing. Although national administrations are at various stages of SHA implementation, the basic methodological framework presented in the SHA Manual is now widely accepted.

2. However, much has in the meantime been learnt from national SHA projects and the Secretariat has received over the years numerous requests for clarifications and further guidelines. Several details in the SHA Manual and of its *International Classification for Health Accounts* (ICHA) apparently require amendment and further clarification. The actual accounting practice in OECD and non-OECD countries has in many cases come up with concrete proposals of how to tackle difficulties and to fill gaps where the SHA manual is not offering all the detail needed for implementation. Several projects commissioned by the EU, as well as from the recent OECD project on *SHA-based health accounts in thirteen OECD countries* have added to this wealth of experience.

3. The purpose of this paper is to present an initial proposal by the Secretariat for refining the ICHA classification by adding more practical guidance for implementation and revising certain of its features in the light of experience gained from SHA implementation. Furthermore, assessment of feasibility of the extension of the ICHA by new dimensions is also suggested.

4. This work of clarification and extension would not concern the basic characteristics of the System of Health Accounts. However, appropriate presentation of the refined version of the ICHA would entail a second edition of the SHA Manual.

5. The paper includes an initial list of the main issues to be addressed, the organisational framework and timing of the project.

6. The Secretariat invites participating experts to:

- COMMENT on the major issues to be covered by the revision process;
- COMMENT on the proposed organisation and timing of the project;
- INDICATE the areas to which they would like to contribute.

INTRODUCTION

7. The SHA Manual provides a standard framework for producing a set of comprehensive, consistent and internationally comparable accounts to meet the needs of public and private-sector health analysts and policy-makers. One of its core elements is the *International Classification for Health Accounts* (ICHA), which currently has three components: classifications for financing, function and provider of health care. Since its release, 26 OECD member countries have either implemented or started the implementation (including preparatory work for the implementation) of the SHA, and an increasing number of non-member countries have also joined the process. The SHA Manual now serves as a quasi-standard for health expenditure reporting. This role is also acknowledged by the NHA guide,[1] published by the WHO, World Bank and USAID, which recommends the SHA Manual as the basis for health accounting in developing countries. Furthermore, in the interest of harmonisation of health data within the European Union, the Statistical Programme Committee of the EU has attached high priority to the implementation of the SHA in EU countries.

8. Future health accounting work at the OECD was given high priority by the responses to the Secretariat questionnaire on member countries' priorities regarding the future work program on health [SG/ADHOC/HEA(2003)21], and by the Communiqué of Health Ministers, issued at the first meeting of OECD Health Ministers held on May 13-14, 2004. Member countries expect the Secretariat to further encourage the implementation of SHA in OECD member countries, as well as to further develop health accounting methodology, in particular health expenditure classification.

9. A key point of the Secretariat's strategy in health accounting is that implementation of the SHA, harmonisation across national practices, analysis and dissemination of results from implementation, and SHA-related developmental works should be performed in a concerted way.[2] Based on the experiences gained during the past four years,[3] this paper summarises the most important issues of the ICHA that require amendment and amplification.

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1. World Bank, World Health Organization, The United States Agency for International Development: *Guide to producing national health accounts with special applications for low-income and middle-income countries*. Geneva. 2003.

2. Presentation and comparative analysis of the SHA tables can reveal the issues needing further harmonisation across countries; experiences from implementation can point out the elements of the SHA methodology needing further development, and refinement of the ICHA can contribute to improvement in comparability of health expenditure data, etc.

3. Numerous sources of the relevant information were considered in order to prepare this report: first of all country reports presented at the *Meetings of Health Accounts Experts* and the SHA-based health accounts country studies published in the *OECD Health Technical Papers*. The *Guide to producing national health accounts*, the Frequently Asked Questions on the WHO SHA web-site, the draft of the SHA Guidelines prepared by the ONS (UK) and the report on "Results of Health Accounts Data in Europe" prepared by the BASYS also should be mentioned.

10. **Basic requirements for the revision of the ICHA are considered as follows:**

- the new version should provide additional guidance to further improve international comparability of health expenditure data;
- it should provide greater flexibility for treatment of differences in national systems within a common framework;
- it should be based on consensus by all international organisations that are users of the manual and have recommended its use in member countries;
- in order to ensure stability, a date should be agreed that the next revision round would not be started before (preferably in 7-8 years); and
- in order to make comparison over time possible, the new version should provide adequate guidance for the transition from the current version to the new one.[4]

11. In order to meet these requirements, an iterative process[5] is envisaged with wide-ranging consultations. Since it requires relatively long time, it is expected that the new version would only be available by mid-2007.

MAJOR ISSUES TO BE COVERED BY THE PROJECT

12. In the following only the most important issues are outlined. In order to base the final concept on as wide as possible experience, health accounting experts in OECD member countries and national health accounting networks outside the OECD will be invited to comment on this initial proposal.

Functional Classification of Health Care (ICHA-HC)

More precise guidelines on health care boundaries

13. The System of Health Accounts provides a consistent functional approach in order to define the boundaries of the health system. At the same time, however, the SHA Manual elaborates on the difficulties in drawing the boundaries for health care expenditure. Experience from SHA implementation has highlighted the fact that the most important factor limiting the international comparability of health expenditure data has been the variance in interpretation of and estimation methods for **long-term care** across countries.[6]

14. The borderline between health and social care is a delicate issue, mainly because public administrations and related statistics traditionally define this borderline in a narrower way in many countries than the SHA. Also, classifications used for National Accounts have a more narrowly defined

4. This is also important, because several countries are just in the course of a SHA implementation project.

5. By iterative process, it is meant that proposals are revised based on the feedback from international health accounting community in three cycles: first this initial proposal is finalised, then the First draft of ICHA 1.1 is produced, and finally, the Draft ICHA.1.1 is completed.

6. It has an effect on the overall magnitude of total health spending (and consequently on health expenditure to GDP ratio), the public-private share of financing, as well as the breakdown by function and provider. Different estimation methods of long-term nursing care may affect total health expenditure by up to more than 10%.

boundary for health than that of the SHA-ICHA. On the other hand, in several countries health and social services are integrated at local governments, so the difficulty is to separate health and social components within the total long-term care expenditure.

15. The other major issue arising from SHA implementation is the borderline between **prevention and public health services** (HC.6) and **health related functions** (HCR.4 Food, hygiene and drinking water control and HCR.5 Environmental health). Important differences in health problems and health care systems (including the administration of public health services) between developing and developed countries might entail different national definitions and accounting practices concerning HC.6. Relevant experience accumulated outside the OECD should also be taken into account during the revision process.

16. In order to improve the comparability of total health expenditure, it is of vital importance to clarify and define more precisely the boundaries of health services, in particular guidelines for the estimation of expenditure on long-term care. This requires wide-ranging consultation, not only across OECD countries, but with leading health accounting experts in non-OECD countries.

More detailed or precise definition of expenditure categories

17. The definitions for each category of ICHA-HC (Functional classification for health accounts), ICHA-HP (Classification of Health Care Providers) and ICHA-HF (Classification of Health Care Financing) are presented in the SHA Manual. However, implementation has shown that more detailed definitions and explanations are needed in some cases in order to avoid large variations in interpretation and estimation practices. Definitions should also be supplemented with more advice concerning estimation methods.

18. As already discussed a more detailed definition is needed for **long-term care**. Definitions and methods of estimation for other functions such as **day care and rehabilitative care** also would profit from further clarifications.

19. A few terms (for example the short-form of “out-patient care” for ambulatory and hospital outpatient services) are used in a different way in the SHA Manual than in the health policy literature and/or everyday practice in some English speaking countries. This can cause ambiguity in interpreting the SHA tables.

20. Definitions of sub-categories of the out-patient services also require clarification and in some cases reconsideration. It might be reasonable to distinguish at three-digit level only among physicians’ services, dental care and other out-patient services; and then at four-digit level to distinguish between basic medical services and specialised health care. Furthermore, in the SHA manual it is written in that way that only specialised medical services provided by physicians should be included in *All other specialised health care* (HC.1.3.3). Obviously, this category should be understood as services provided by or under the supervision of physicians.

21. A debated feature of the ICHA-HC is the different treatment of clinical laboratory and diagnostic imaging services provided for out-patients and in-patients. *Ancillary services to health care* (HC.4) includes only clinical laboratory and diagnostic imaging services provided to out-patients; and when these services are provided to in-patients they are included in in-patient care.[7] The treatment of ancillary services for outpatients is based on a “medical procedures approach”, at the same time, the treatment of ancillary services for inpatients is based on an “episode of care approach” (it is included in inpatient care, not in HC.4). As a result, inconsistencies in the concept of curative care occur: *Expenditure on curative care* includes clinical laboratory and diagnostic imaging provided for in-patients, while it does not include

7. Similarly to HC.5 medical goods dispensed to out-patients.

clinical laboratory and diagnostic imaging provided for out-patients (because they are included in ancillary services (HC.4).

22. Implementation has also shown that in most countries data are not available at the three-digit level for sub-categories of *Therapeutic appliances and other medical durables*. In similar cases fewer three digit level categories might be desirable for international purposes. The issue of re-utilisation of therapeutic appliances should also be addressed. (In some Nordic countries the rate of re-utilisation of therapeutic appliances accounts for at least half of the appliances)

23. There is a contradiction between the classification of the Occupational health care (OHC) under the ICHA and its definition: The ICHA-HC classifies OHC (HC.6.5.) under "Prevention and public health services" (HC.6.). The definition of the OHC, however, includes also curative and rehabilitative care (as subcategories of prevention). There seem to be two possibilities: (1) modify the way OHC is ranked in the ICHA; (2) correct the definition of the OHC. If the definition of the OHC were consistent with its classification, it should only include preventive services (mainly medical check-ups required to do the particular Economic activities).

24. Further guidance is needed to improve comparability of the statistics on gross fixed capital formation. This is an important expenditure category for policy analysis. However, no health account in OECD countries is currently able to provide a comprehensive estimate.

25. A few minor inconsistencies have been discovered following the publication of the Manual that require correction.[8]

26. The Manual needs a thorough examination and review of these and other potentially ambiguous terms to decide where a modification of the terms used and/or the provision of more elaborate explanations are the appropriate strategies for improvement.

More detailed clarification of the relationship between the two approaches of functional classification

27. The OECD SHA Manual combines two approaches in functional classification of personal health services: (i) "functions" in terms of the purpose of health care (curative care, rehabilitation and long-term care, etc.); and (ii) the mode of production that reflect technical and organisational features of care (inpatient care, day care, outpatient care and home care). The treatment of these two approaches is ambiguous in the SHA Manual: in the basic tables of Chapter 2, mode of production is the first level and curative-rehabilitative and LTC are subcategories under inpatient and out-patient care, etc. While in the section presenting the classification, mode of production is presented as sub-categories under curative-rehabilitative and LTC. An appropriate solution for this problem might involve more detailed explanation, and/or modification in the standard tables and/or in the structure of the functional classification.

Classification of Health Care Providers (ICHA-HP)

28. The ICHA-HP has proved to be too detailed at the second digit level. For example, *Nursing and residential care facilities* (HP.2) has four items at two-digit level that are not likely to be in correspondence with the system characteristics in a number of OECD countries. In fact, *Providers of ambulatory health care* (HP.3) is the only category, for which most countries can provide more sub-aggregated data (that is

8. For example, both under HC.6.3 (Prevention of communicable diseases) and HC.6.1 (Maternal and child health) it is mentioned that the category includes vaccination for children. It obviously should be decided which category includes and which does not.

two-digit level subcategories). If the two-digit level is considered the required level for international comparability, the current two-digit categories need a thorough review from this point of view.

29. In several countries complex health centres might provide – besides ambulatory care – some in-patient curative care, long-term care, and public health services, etc. Furthermore, they might also offer social services. At this moment out-patient care centres (HP.3.4.) is suggested for accounting these institutions, but obviously it is not an optimal solution. Taking into consideration their importance in several countries, these complex institutions need an independent category in the ICHA-HP.

30. Providers of oriental (traditional) medicine currently are included under offices of other health practitioners (HP.3.3). This category usually includes self-standing non-physician practitioners (*e.g.*, physiotherapists). However, in several countries doctors (graduated from oriental medical schools) provide oriental medicine. Hence, it would be more consistent – from a provider point of view – to account doctors (but not the other practitioners) providing oriental medicine as a subcategory under offices of physicians (HP.3.1).

31. Moreover, in the provider classification, certain terms can be read as functions rather than providers (*e.g.*, HP.5 Provision and administration of public health programmes). They need to be reworded.

Classification of Health Care Financing

32. Thee important elements of health care financing – namely ultimate sources of funding, financing schemes (*e.g.*, compulsory insurance or voluntary insurance, etc.) and financing agents[9] (organisations managing the financing schemes) – requires unambiguous treatment. The term "health care financing" used for the ICHA-HF in the SHA Manual could be interpreted in different ways: as referring to financing agents, financing schemes or final sources of funding.

33. Although the term "private social insurance" is used precisely in the SHA Manual, as defined by the SNA, it is widely debated. Partly, because the term "private social insurance" is rarely used in health policy analysis. This is an example, where the discussions under this proposed project could potentially provide input in the current revision round of the System of National Accounts (SNA 2008).

34. A few theoretical issues should also be addressed when reviewing definitions. For example, the Manual does not address how the tax-allowances for private insurance should be treated.

35. The SHA Manual should provide more guidance for accounting investments financed by private providers such as hospitals (from a financing agent point of view). One option to be discussed is creating sub-categories under non-profit institutions and corporations, for example for hospitals (as financing agents).

36. Three-digit level subcategories of private household out-of-pocket expenditure are too detailed. Three categories in place of the current nine categories might be more feasible to estimate (out-of-pocket payments excluding cost-sharing; cost sharing related to public financing; and cost-sharing related to private insurance).

9. There is no one-to-one relationship between the financing schemes and financing agents. For example, a compulsory insurance program can be managed by both quasi-public institutions and commercial insurance companies at the same time in a particular country; and social insurance organisations might also provide voluntary insurance.

Common issues for the three basic dimensions

Comparability versus flexibility

37. Currently SHA-ICHA has two or three digit level categories. A number of countries have added more detailed categories (at three or four digit level), while figures for some of the two digit level categories of the SHA-ICHA are not reported by the majority of countries. It would be reasonable to agree that international comparability is required at two-digit level, hence national systems should try as strictly as possible to follow the definitions and categories of SHA-ICHA at this level; and it would be desirable to define country-specific categories below this level. If it would be agreed, the structure of the ICHA should be reviewed from this point of view.

International comparability versus national statistics

38. Currently, several countries present different values of total expenditure for national and international reporting purposes (for example Denmark, Japan and the United States, etc.). Although this situation is likely to continue, a more harmonised practice could be developed for the presentation (and interpretation) of different national and international estimates.[10]

More precise cross-classification with other international classification of health care

39. Annex 9.2 and Annex 10.1 in the SHA Manual provide tables presenting cross-classification with classifications used in the SHA 93, namely the International Standard Industrial Classification of all Economic Activities (ISIC); Classification of Individual Consumption by Purpose (COICOP) and Classification of the Functions of the Government (COFOG). However the mapping between the ICHA-HC and the COICOP and COFOG, and between the ICHA-HP and ISIC would profit from more explanations.[11]

Possible extension of the ICHA

40. Currently the SHA-ICHA provides three classifications: ICHA-HC: Functional classification for health accounts, ICHA-HP: Classification of Health Care Providers and ICHA-HF: Classification of Health Care Financing. Extension of the ICHA with three new dimensions – namely, (ultimate) financing sources, beneficiary population (by age and gender), and resources (used to produce health services and goods) deserves consideration.[12] Additional dimensions would naturally involve that additional SHA tables be defined.[13]

41. Although the relationships between final sources of funding and financing schemes/financing agents are discussed in the SHA Manual, it does not explicitly present a classification system for the final sources as a standardised way to summarise the set of tables presented in Chapter 6. An SHA table

10. For example, should tables with international data refer to the fact that the data in national statistics differ?

11. In the interest of better harmonisation among classification systems, in 2003 the Secretariat put forward a proposal for treatment of health in the ongoing revision of ISIC [DELSA/ELSA/WP1/HS(2004)7].

12. Overall, the WHO Producers Guide proposes the following additional dimensions: financing sources (in the sense of ultimate sources of funding); beneficiary population (classification by demographic characteristics, socioeconomic characteristics, health status / disease state); resources used to produce health care goods and services. It will not be possible to address all these dimensions in the current revisions.

13. Obviously, cross-classification of these new dimensions would not be reasonable with all the existing three dimensions.

providing clear picture about the relationship between ultimate sources and financing agents would be desirable.

42. Analysis of the initial results from SHA implementation has shown that some important policy questions can not be answered from the current SHA Tables: for example, the total usage of pharmaceuticals or total manpower costs. One option for obtaining this information would be to create a new dimension of resources (inputs) for health care.[14]

43. Three basic requirements should be considered for deciding on whether to incorporate a new dimension into the ICHA: policy relevance, feasibility of measurement and possibility of regular reporting.

OUTCOME OF THE PROJECT

44. **SHA-ICHA Version 1.1** is expected to fulfil better the requirements of a tool for improved international comparability and at the same time have more flexibility to accommodate different national health systems. It is desired that the new version be based on consensus amongst the international organisations concerned.

45. A revised version of the SHA-ICHA obviously will require revision of the standard tables and modifications in the text of most chapters of the SHA. Therefore, issuing of a **second edition of the SHA Manual** seems to be the most reasonable solution to present the SHA-ICHA Version 1.1.

46. The second edition, however, will not change the following basic theoretical chapters: Measurement of Expenditure on Health Care, Price and Volume Measurement and The SHA and Health Satellite Analysis and Accounts.

14. Another option would be to create a sub-categories under inpatient care for pharmaceuticals and ancillary services at three-digit level.

SUGGESTIONS FOR ORGANISATION AND TIMING OF THE PROJECT

47. The project requires an organisational framework that is able to facilitate development of consensus among international organisations, involvement of wide circle of experts inside and outside the OECD, and at the same time ensure effective management.

48. The organisation of the project is to include the following elements:

- The project will be supervised by an international **Supervisory Board.** (Participation will be invited from appropriate Directorates of the European Commission, WHO, and the World Bank, as well as OECD ELS and OECD Statistics Directorate.) The **Supervisory Board** will discuss the proposals put forward by the Working Group which is responsible for the professional work.
- The project is to be co-ordinated by a **project manager at the OECD**.
- Professional work will be led by a **Working Group** consisting of 4-5 members: the project manager (OECD) and 3-4 experts from member countries.
- A wider circle of **experts** should also be involved concerning particular issues (in the framework of consultant contracts).

49. To facilitate discussions in a wider circle of experts, an **Electronic Discussion Group** (SHA EDG) for the *Network of Health Accounts Experts and Correspondents for Health Expenditure Data* will be launched.

50. Intermediary drafts will be discussed at the ***Meetings of Health Accounts Experts.***

51. The project will profit from consultations with other directorates at the OECD involved in health related activities (*e.g.* Development Co-operation Directorate) and general accounting standards (*e.g.*, National Accounts Division in the Statistics Directorate).

52. Finally, the decisions on the scope of the project of refining the ICHA classification will have to be matched with available resources. The OECD programme of work and budget for 2005/2006, and the allocation to health work within that budget, has not yet been finalised. The funds which will be available to carry out this project itself, and to give further attention to statistics on long-term care expenditure and services are therefore not yet known. Depending on the scope of the project, there may therefore be a need for raising additional funding.

Co-operation with other international organisations and expert networks outside OECD

53. For the key organisational issues of the co-operation, the proposals are as follows:

- Representatives of international organisations (indicated in the previous section) will be invited to serve as members of the Supervisory Board.
- It should be the responsibility of members of the Supervisory Board to disseminate the relevant material in their expert constituency and transmit their opinion to the Supervisory Board.
- The Secretariat will send the relevant material to the leaders of the SHA networks both within and outside the OECD to seek their consolidated opinion.

Time framework:

54. A possible deadline for publishing SHA-ICHA Version 1.1 might be mid-2007. The table below presents the proposed process:

Tasks	Deadlines
Discussion of the Draft project proposal at the Meeting of Health Accounts Experts	October
Establishing the Electronic Discussion Group for the Network of Health Accounts Experts	October
Deadline for comments on the initial proposal [HS(2004)6]	Mid-November
Establishing the Working Group Discussion of the revised project proposal	December 2004
Establishing the Supervisory Board Discussion of the revised project proposal	January 2005
Final project proposal accepted	**January 2005**
Invitation of experts (or expert teams) to elaborate specific parts of the ICHA Version 1.1.	February 2005
First drafts by invited experts (or expert teams) submitted to the Working Group / Meeting of the Working Group: preparing the ***First draft of ICHA 1.1***	**June 2005**
Putting the *First draft of ICHA 1.1* on the EDG	June/July 2005
Discussion of the *First draft of ICHA 1.1*. by the Meeting of Health Accounts Experts	October 2005
Requesting comments from networks outside the OECD	December 2005
Discussion with the OECD relevant directorates	December 2005
Revision of the First draft of ICHA 1.1 by the Working Group: producing the *Final Draft of ICHA 1.1*	February 2005
Discussion of the *Final Draft of ICHA 1.1* by the Supervisory Board	March 2006
Final Draft of ICHA 1.1 finalised by the Working Group	**April 2006**
Wide-range discussion of the **Final Draft of ICHA 1.1**	May – October
Discussion of the **Final Draft of ICHA 1.1** by the Meeting of Health Accounts Experts	October 2006
Finalising the publication by the Working Group and the OECD Secretariat	January/February 2007
Acceptance of the publication by the Supervisory Board	March 2007
Publication of the ICHA 1.1	**May-June 2007**